Summary of South Carolina Healthy Connections Waiver

Component	Description
Reform Authority	Section 1115(a)(1) Research and Demonstration Waiver (CMS has not yet approved this waiver.)
Reform Name	• South Carolina Healthy Connections •
Time Frame	• Submitted to CMS November 16, 2005. • While waiting for approval, SC hopes to enroll more Medicaid recipients in managed care.
Goals	• Provide more individual choice for Medicaid recipients. • Introduce more competition and choice in the Medicaid system. (Have plans compete by offering array of benefit packages and prices for different groups.) • Produce cost savings and better care for Medicaid recipients.
Main Program Elements	• Personal Health Accounts (PHA) • Self-Directed Plans • Employer-Sponsored Insurance (ESI) • Cost Sharing
Quick Summary	• The State will develop risk-adjusted premiums or Personal Health Accounts (PHAs) that recipients can use to shop around for a variety of providers. State will still pay for services if a recipient exceeds his PHA. • Medicaid beneficiaries will have a choice of enrolling in several different types of health plans including pre-paid plans (MCOs), PCCMs, Employer-Sponsored Insurance, and Self-Directed Plans similar to Health Savings Accounts. Benefits offered will vary by health plan. • The Self-Directed Plans will offer recipients the greatest choice of options and the State indicates that this component will only be offered to individuals who demonstrate that they are capable of managing their own care.
Populations Covered	• All full Medicaid beneficiaries are covered by the waiver except for: dual eligibles, foster care children, and family planning waiver recipients. • Long Term Care Services are excluded from the waiver. • Expansion population: uninsured family members who get coverage when a Medicaid-eligible individual enrolls in their employer's plan, and individuals that lose eligibility but still have a balance in their PHA and can use that balance for medical services for 12 months or until the balance is exhausted.
Enrollment	• Newly Medicaid eligible will be enrolled in the reform waiver upon becoming eligible. • Current beneficiaries will be enrolled in the reform waiver at the time of their eligibility redetermination.
Service Providers	• Pre-Paid Plans-- Choice of MCO or PPO

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	• Medical Homes Network--PCCM networks with Family Physicians as gatekeepers administered by a formal administrative services organization (ASO). PCP must sign agreement with the State. • FFS--will be maintained for eligibility categories excluded from reform program, while State transitions to reform program, and as an option for disabled children. • Employer/Group Insurance Assistance—Employer-provided plans • Self-Directed Care Pilot Program—Similar to a Health Savings Account. Part of the PHA would pay for a major medical insurance plan (essentially, inpatient services and related care). State will contract with a vendor to provide administrative framework for this component. Hospitals will bill Medicaid on FFS basis as done currently for Medicaid-eligible recipients.
Benefit Packages	• Benefits determined by eligibility group and by the health plan chosen. • Services for all children (under 19), regardless of plan, cannot be more restrictive than current Medicaid State Plan services. Pre-Paid Plans • For adults, package must include, at a minimum: all mandatory services, plus pharmacy and DME. Package must meet the federal requirement for amount, duration and scope. Package may be more limited in scope than the current State Plan for one or more individual services. Thus, the premium charged by the plan may be lower than the PHA for that beneficiary. Beneficiaries may use any residual in PHA for services not covered, or to cover cost sharing. • Children will receive all mandatory and optional services, including EPSDT. Medical Home Network • Must include all Mandatory and Optional services. Premium is actuarially equivalent to current FFS experience (and requires full PHA). Employer/Group Insurance Assistance • Whatever services are covered by employer's plan, with whatever cost sharing employer's plan has. (No wrap-around provided by the State.) Self-Directed Care Pilot Program • Catastrophic coverage plus selected screenings and preventive care. Insurance limited to major medical coverage that includes only inpatient hospital coverage and related costs plus preventive services. Other • Non-emergency medical transportation will be addressed outside of the reform waiver through a regional transportation broker. • Medicaid Services Excluded from the waiver: o Nursing Home Services greater than 28 days o Home and Community Based Services Applicable to the Following Waivers: Elderly/Disabled, HIV/AIDS, Assisted Living, Vent, MR, Head and Spinal Cord Injury. o Non-Emergency Transportation Services o Services Funded by State Agencies o Integrated Personal Care Services o Behavioral Heatlh Services o Residential care Facility Services o SMI Premiums

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	o PACE Program o Family Planning Waiver Expenditures o Medicaid Disproportionate Share Program o Medicaid Cost Settlements o Transplant Services
Personal Health Accounts (PHAs)	• PHA based on risk adjusted current FFS expenses. • Initially PHAs are for individuals; the goal is to offer family PHAs later. • The value of a beneficiary's PHA is based on the current Medicaid benefit package. • A prepaid plan's premium cannot exceed the value of the benefit package they offer. If the benefit package offered by a plan is not as great in overall scope or value as the current Medicaid program, the plan cannot charge a premium that is equal to the PHA. If the package is less than the current Medicaid package, the beneficiary can use residual in PHA to pay for cost sharing or services not covered by plan. • In the two "Option-Out" programs (ESI and Self-Directed Plan), beneficiaries choose to receive medical care outside the Medicaid program and Medicaid only provides a defined amount of financial support. • For recipients in a pre-paid health plan, the plans are only at risk up to a certain level. After that, the State assumes most of the risk, acting as a reinsurer. If a self-directed participant exhausts his PHA and needs health services, he will be moved into a full service plan. His liability is limited to a defined "gap" amount (out-of-pocket maximum).
Payment to Plans	• Pre-Paid Plans—MCOs or PPOs set the level of benefits and adjust their premium accordingly. State pays the plan up to the PHA amount. State will provide reinsurance: Plan will be at risk for full cost of care up to a determined amount; above that amount the plan will pay a small percentage of the cost and the State will pay the rest. • Medical Homes Network—PCPs sign agreements with the State and are paid on a FFS basis plus a PMPM case management fee. ASOs must contract with state and are in charge of helping provider networks with case management, and disease management. State determines expected costs for MHN beneficiaries and ASOs share any difference (loss or savings) with the State. ASOs paid administrative fee and claims processed on a FFS basis. State hopes to convert ASOs into Prepaid Ambulatory Healthcare Programs (PAHPs) which assume more risk and process claims. • Employer/Group Insurance Assistance (ESI)—The State pays up to the amount it would have paid to cover recipient under Medicaid. (If ESI premium is higher, recipient pays the difference.) • Self-Directed Care Pilot Program—Similar to a Health Savings Account. Part of the PHA would pay for a major medical insurance plan. Providers of major medical services will be reimbursed under FFS system. State will contract with a vendor to provide administrative framework for this component. Beneficiaries would choose how to spend the rest on other medical services that they would purchase directly from providers at Medicaid FFS rates. The State plans to contract with a vendor to administer this component.

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Cost Sharing	• Reform plan keeps co-payments for primary and preventive care at current nominal levels or even decreases them in some cases. Other forms of care would have somewhat higher co-payments. Health plans are provided with maximum co-payments for State Plan services. For services not covered currently under the State Plan, health plans are free to determine the co-pay. • The following beneficiaries not subject to co-pays: children, pregnant women, institutionalized individuals and those in home and community based waivers. Family Planning Services not subject to co-pays. • Maximum out-of-pocket limits: $250/individual, $400/family. • Providers can withhold non-emergency services until payment plan for co-payments is established and can terminate services if payment plan is not followed.